STATE OF MARYLAND

Request for Proposals
Mental Health and Substance Abuse Services

Solicitation No. F10R0200267

Department of Budget and Management
Employee Benefits Division
February 22, 2000

NOTICE

Prospective offerors who have received this document from a source other than the Issuing Office should immediately contact the Issuing Office and provide their name and mailing address so that the amendments to the RFP or other communications can be sent to them.

Minority Businesses are Encouraged to Respond to this Solicitation

NOTICE TO OFFERORS

In order to help us improve the quality of State proposal solicitations, and to make our procurement process more responsive and "business friendly", we ask that you take a few minutes and provide comments and suggestions regarding the enclosed solicitation. Please return your comments with your proposal. If you have chosen not to bid on this contract, please fax this completed form to: (**410 333-7122**).

Proposal Number: **Solicitation No. F10R0200267**
Entitled: **Mental Health and Substance Abuse Services**
Date: **February 22, 2000**

1. If you have responded with a Ano bid≅, please indicate the reason(s) below:
   - P Other commitments preclude our participation at this time.
   - P The subject of the solicitation is not something we ordinarily provide.
   - P We are inexperienced in the work required.
   - P Specifications are unclear, too restrictive, etc. (please explain in the Remarks section).
   - P The scope of work is beyond our present capacity.
   - P Doing business with State of Maryland Government is simply too complicated (please explain in the Remarks section).
   - P We cannot be competitive (please explain in the Remarks section).
   - P Time allotted for completion of the proposal is insufficient.
   - P Start-up/implementation time is insufficient.
   - P Proposal requirements (other than specifications) are unreasonable or too risky (please explain in the Remarks section).
   - P MBE requirements (please explain in the Remarks section).
   - P Prior State of Maryland contract experience was unprofitable or otherwise unsatisfactory (please explain in the Remarks section).
   - P Payment schedule is too slow.

Other:

2. If you have submitted a proposal, but wish to offer suggestions or express concerns, please use the Remarks section below (use reverse or attach additional pages as needed).

REMARKS:

Vendor Name:_____ Date:

Contact Person:_____ Phone:

Address:

PROCUREMENT SCHEDULE

Mental Health and Substance Abuse Services

February 22, 2000	Advertisement of the Request for Proposals for Mental Health and Substance Abuse Services in Maryland Contract Weekly and Issuance of Request for Proposals
March 3, 2000	Requested date for receipt of written questions to be answered during the pre-proposal conference. Must be received at the Issuing Office by 10:00 a.m. local time.
March 7, 2000	Pre-proposal Conference at 1:00 p.m. 300 West Preston Street - 1st floor auditorium Baltimore, MD 21201
April 12, 2000	Closing date for submission of proposals. Proposals must be received at the Issuing Office by 1:00 p.m.
May 15-19, 2000	Vendor Interviews (tentative)
July 19, 2000	Recommendation for Award at Board of Public Works Meeting

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SECTION I. GENERAL INFORMATION

1.1 SUMMARY STATEMENT

The Department of Budget and Management is soliciting proposals to provide a single health plan for Mental Health, Alcohol and Substance Abuse (MHSA) benefits and Employee Assistance Program (EAP) benefits. MHSA benefits are requested for state members and their dependents who participate in a Preferred Provider Organization or a Point of Service (PPO/POS) medical plan. EAP benefits are requested for active State employees, irrespective of the employee's participation in a State medical plan. The State will contract with one vendor for the desired services.

1.2 DEFINITIONS

For the purposes of this RFP, the following terms have the meanings indicated below:

AALOS≅ means average length of stay.

ACOB≅ means Coordination of Benefits.

ACOBRA≅ means Consolidated Omnibus Budget Reconciliation Act.

ACOMAR≅ means Code of Maryland Regulations

AContract Employee≅ means a non-permanent employee of the State of Maryland who is not eligible for State subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program, paying full premium costs.

ACovered Lives≅ means each individual enrolled in a plan.

ACPT≅ means current procedural terminology.

ADBM≅ means the Department of Budget and Management

ADRG≅ means diagnostic related group.

ADependent≅ means a spouse, natural child, step-child, legally adopted child, or legal ward of an eligible member, as defined in COMAR 06.01.07.03A(11).

ADirect Pay Enrollee≅ means an individual who is billed directly by DBM (i.e., COBRA enrollees, contract enrollees, etc.).

AEAP≅ means Employee Assistance Program.

AEASNA≅ means Employee Assistance of North America

AEBD≅ means Employee Benefits Division.

AEDI≅ means Electronic Data Interface.

AEOB≅ means Explanation of Benefits.

AEST≅ means Eastern Standard Time.

AFTE≅ means Full-Time Equivalent.

AHIPAA≅ means Health Insurance Portability Accountability Act.

AHMO≅ means health maintenance organization plan.

AICD-9" means International Classification of Diseases - 9.

AJCAHCO≅ means Joint Commission on Accreditation of Health Care Organization.

ALeave of Absence≅ means a permanent employee who has elected a non-paid level of absence from State of Maryland employment, who is not eligible for state subsidy of benefits, but is eligible to participate in certain benefits provided by the State of Maryland while on a leave of absence.

AMBE≅ means a Minority Business Enterprise that is certified by the Maryland Department of Transportation.

AMHSA≅ means Mental Health and Substance Abuse.

AMember≅ means an employee who is eligible to participate in the State of Maryland Benefits Program but does not include the member=s dependents.

AMIS≅ means Management Information System.

AOPSB≅ means Office of Personnel Services and Benefits.

APOS≅ means point of service plan.

APPO≅ means preferred provider organization plan.

APart-Time Employee≅ means a permanent employee who works less than fifty percent of the standard workweek and is not eligible for state subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program.

APlan Sponsor≅ means the State of Maryland.

ARFP≅ means this Request for Proposal.

ASAAC≅ means Substantial, Available, and Affordable Coverage.

ASPD≅ means summary plan description.

ASatellite Account Employee≅ means an employee of a political subdivision, agency, commission, or organization that is permitted by Maryland law to participate in the State of Maryland Benefits Program.

ATPA≅ means Third Party Administrator.

ATTY/TDD≅ means a telephone device used by hearing impaired individuals whereby they communicate via telephone connected to a keyboard and screen.

1.3 ISSUING OFFICE AND PROCUREMENT OFFICER

The sole point of contact in the State for purposes of this RFP is the Issuing Office at the address listed below:

Department of Budget and Management
Employee Benefits Division
301 West Preston Street, Room 509
Baltimore, Maryland 21201
Attn: Gladys B. Gaskins
Telephone: (410) 767-4710
Fax: (410) 333-7122

The Procurement Officer is Joel Leberknight, 45 Calvert Street, Room 137, Annapolis, Maryland 21401, (410) 260-7116, Facsimile: (410) 974-3274.

1.4 PRE-PROPOSAL CONFERENCE

A Pre-Proposal Conference will be held on Tuesday, March 7, 2000 beginning at 1:00 p.m. in the auditorium located on the 1st floor, 300 West Preston Street, Baltimore, Maryland

21201. Attendance at the Pre-Proposal Conference is not mandatory, but all interested offerors are encouraged to attend in order to facilitate better preparation of their proposals. The conference will be transcribed. A copy of the transcript of the pre-proposal conference will be made available to potential offerors at a nominal charge directly from the transcription company. In addition, minutes of the conference will be distributed, free of charge, to all vendors who are known to have received the RFP. Both written and verbal questions will be considered at the pre-proposal conference.

All questions, either verbal or written, should be submitted in a timely manner. In the case of questions not received in a timely manner, the Procurement Officer shall, based on the availability of time to research and communicate an answer, decide whether an answer can be given before the proposal due date. Answers to all substantive questions which have not previously been answered, and are not clearly specific only to the requestor, will be distributed to all vendors who are known to have received the RFP.

1.5 PROPOSAL DUE (CLOSING) DATE

Except as provided in COMAR 21.05.02.10, the proposals are to be received by the Issuing Office, no later than Wednesday, April 12, 2000 at 1:00 p.m., local time, EST. Proposals may not be submitted by e-mail or facsimile.

1.6 DURATION OF OFFER

Proposals submitted in response to this RFP are irrevocable for 120 days following the closing date. This period may be extended at the Procurement Officer's request only by an offeror's written agreement.

1.7 REVISIONS TO THE RFP

If it becomes necessary to revise this RFP, amendments will be provided to all prospective offerors that were sent this RFP or otherwise are known by the Procurement Officer to have

obtained this RFP. Acknowledgement of the receipt of all amendments to this RFP must accompany the offeror's proposal. Failure to acknowledge receipt does not relieve the offeror from complying with all terms of any such amendment.

1.8 CANCELLATION; DISCUSSIONS

The State reserves the right to cancel this RFP, accept or reject any and all proposals, in whole or in part, received in response to this RFP, to waive or permit cure of minor irregularities, and to conduct discussions with all qualified or potentially qualified offerors in any manner necessary to serve the best interests of the State of Maryland. The State also reserves the right, in its sole discretion, to award a contract based upon the written proposals received without prior discussions or negotiations.

1.9 ORAL PRESENTATION

Offerors may be required to make individual presentations to State representatives in order to clarify their proposals. Any statement made by an offeror during an oral presentation that significantly alters its proposal must be reduced to writing. Any such written submission becomes a part of the offeror's proposal.

1.10 INCURRED EXPENSES

The State will not be responsible for any costs incurred by an offeror in preparing and submitting a proposal, in making an oral presentation, in providing a demonstration, or in performing any other activities relative to this solicitation.

1.11 ECONOMY OF PREPARATION

Proposals should be prepared simply and economically, providing a straightforward, concise description of the offeror's proposal to meet the requirements of this RFP.

1.12 DISPUTES; PROTESTS

Any protest or dispute related respectively to this solicitation or the resulting contract shall be subject to the provisions of COMAR 21.10 (Administrative and Civil Remedies).

1.13 MULTIPLE AND ALTERNATIVE PROPOSALS

An offeror may not submit multiple proposals for the required services under this RFP.

An offeror may submit an alternative proposal for the required services in addition to a proposal which fully conforms to the requirements of the RFP. This required fully conforming proposal shall be deemed to be the primary proposal. An alternative proposal, by definition, is a proposal which seeks to satisfy the overall objectives of this RFP, but which in some ways takes exception to one or more specific requirements of this RFP. An alternative proposal may be selected for award if its proposed solution for providing the described services required under this RFP is judged superior to any proposal which does not take exception to any requirement of this RFP.

An alternative proposal must be clearly labeled as such and follow the same format as the primary proposal. However, an alternative proposal should contain only that information that differs in any way from the primary proposal. Each proposal must be bound separately and prepared in accordance with Section 5 of this RFP.

1.14 ACCESS TO PUBLIC RECORDS ACT NOTICE

An offeror should give specific attention to the identification of those portions of its proposal that it considers confidential, proprietary commercial information or trade secrets, and provide justification why such materials, upon request, should not be disclosed by the State under the Access to Public Records Act, Title 10, Subtitle 6, of the State Government Article of the Annotated Code of Maryland. This information is to be placed after the title page and before the table of contents in both the technical and financial proposals. Respondents are

advised that, upon request for this information from a third party, the Department is required to make an independent determination whether the information may be disclosed (see COMAR 21.05.08.01).

1.15 OFFEROR RESPONSIBILITIES

The selected offeror shall be responsible for all products and services required by this RFP. Subcontractors, except those used to exclusively meet MBE participation goals, must be identified and a complete description of their role relative to the proposal must be included in the offeror's proposal. Additional information regarding MBE subcontractors is required under paragraph 1.19 below.

1.16 MANDATORY CONTRACTUAL TERMS

By submitting an offer in response to this RFP, an offeror, if selected for award, shall be deemed to have accepted the terms of this RFP and the Contract - Attachment A. Any exceptions to this RFP or the Contract must be clearly identified in the Executive Summary of the technical proposal. A proposal that takes exception to these terms may be rejected.

1.17 PROPOSAL AFFIDAVIT

All proposals submitted by an offeror must be accompanied by a completed Proposal Affidavit. A copy of this Affidavit is included as Attachment B of this RFP.

1.18 CONTRACT AFFIDAVIT

All offerors are advised that if a contract is awarded as a result of this solicitation, the successful offeror will be required to complete a Contract Affidavit. A copy of this Affidavit is included for informational purposes as Attachment C of this RFP. This Affidavit must be provided upon notification of proposed contract award.

1.19 MINORITY BUSINESS ENTERPRISES

A Minority Business Enterprise subcontract participation goal of 15 percent of Total Administrative Fees found in the Financial Proposal, Attachment K, has been established for this procurement. The contractor shall structure its awards of subcontracts under the contract in a good faith effort to achieve the goal through businesses certified by the State of Maryland as minority owned and controlled. MBE requirements are specified in Attachment D of this RFP.

A current directory of MBEs is available through the Maryland State Department of Transportation, Office of Minority Business Enterprise, P. O. Box 8755, B.W.I. Airport, Maryland 21240-0755. The phone number is (410) 865-1244. The directory is also available at http://www.mdot.state.md.us, select "MBE".

1.20 ARREARAGES

By submitting a response to this solicitation, each offeror represents that it is not in arrears in the payment of any obligations due and owing the State of Maryland, including the payment of taxes and employee benefits, and that it shall not become so in arrears during the term of the contract if selected for contract award.

1.21 PROCUREMENT METHOD

This contract will be awarded in accordance with the competitive sealed proposals process under COMAR 21.05.03.

1.22 CONTRACT DURATION

The contract resulting from this RFP shall be for the period beginning on or about July 1, 2000 and ending on or about December 31, 2003. The offeror shall be responsible for providing Mental Health/Substance Abuse and EAP services for calendar years 2001, 2002 and 2003. The State, at its sole option, shall have the right to extend the contract term for

three additional, successive one year terms. For the period from contract commencement until December 31, 2000, the contractor shall be responsible for the activities described in Section 3.4. Beginning January 1, 2001, the contractor will also be responsible for processing claims incurred on or after January 1, 2001. Following the end of this contract (including any one-year extension(s) exercised by the State), the contractor shall be responsible for handling claims runout payments for claims incurred prior to the end of the contract for a period of 18 months following contract expiration.

1.23 CONTRACT TYPE

The contract to be awarded shall be a fixed unit price contract for administrative expenses plus reimbursement of claims cost.

1.24 PAYMENT TERMS

If the State exercises its option to extend the contract, any administrative rate increase applicable to years 2004, 2005 and 2006 shall not exceed the amounts specified in this paragraph. The administrative rate increase shall be measured by the change in the "Medical Care" expenditure category of the Consumer Price Index for all Urban Consumers for the Baltimore-Washington published metropolitan area, unadjusted for seasonal variation (hereinafter "CPI-U Medical"). The measurement period shall be the twelve-month period ended June 30, preceding the option period. The increase determined under this paragraph shall be applied to the administrative rates in effect for the prior year of the contract.

The contractor shall not receive compensation for implementation services described under Section 3.4 performed prior to January 1, 2001.

As described in Section 1.22, the contractor shall provide claims run out payments and related administrative services for up to 18 months following the end of the contract and shall be entitled to payment for such services as performed.

SECTION 2. OFFEROR QUALIFICATION

Offerors must clearly state and demonstrate within the Executive Summary of their proposals that they have three years' experience administering Mental Health, Alcohol and Substance Abuse program benefits for more than 50,000 covered lives.

SECTION 3. SPECIFICATIONS

3.1 PROGRAM DESCRIPTION

Mental Health and Substance Abuse Benefits (MHSA)

The State currently offers MHSA benefits to employees enrolled in the State's medical plans through two different arrangements:

1. MHSA benefits are offered to PPO and POS medical plan participants through a self-insured contract with Magellan (formerly Greenspring Health Services). This is the contract being bid through this RFP.

2. MHSA benefits for participants in the State's five fully insured HMO plan options are provided directly through the HMO in which each participant is covered. MHSA services for HMO participants are not included in the scope of services for this contract.

Specific features and coverage levels for the State's MHSA plan are described in Attachment E.

Currently enrollment for the State's two PPO plans and three POS plans is approximately 75,000 employees and retirees, or approximately 79% of the State's total medical plan participants, including COBRA. Specific enrollment statistics for the State's medical programs are presented in Attachment M.

Employee Assistance Program (EAP)

The State offers certain EAP benefits to active employees (whether they have elected medical plan participation or not) who are referred by management to the EAP unit in the Office of Personnel Services and Benefits (OPSB). EAP counseling services are provided only by an EAP network provider under contract to and certified by the EAP contractor (currently Magellan Health Services).

The Agency EAP coordinator forwards a confidential EAP Supervisory Referral Form to the EAP administrative staff. EAP administrative staff are responsible for scheduling the initial appointment, conducting follow-up, providing feedback to the Agency EAP coordinator, and monitoring any employee who, pursuant to COMAR 17.04.09 is required to receive rehabilitation services.

Employees are limited to a total of three hours of EAP counseling per occasion of referral. There is no co-payment paid by the employee if the visit has been authorized by the State's EAP Unit. Current EAP utilization information is provided in Attachments K. An EAP supervisory referral form is provided as Attachment L.

3.2 DESIRED PLAN DESIGN

The State intends to continue the current MHSA and EAP plan designs as fully outlined in Attachment E. Current copays, benefit limitations and exclusions will remain in effect throughout the term of the contract resulting from this RFP, except as changes to the program are required due to legislative or regulatory mandates.

3.3 SCOPE OF WORK

The contractor shall provide the following services under this contract:

A. Network

Establish and manage a network of MHSA providers that will deliver quality professional services and make appropriate referrals when necessary. Provider networks should demonstrate the following:

(1) A wide selection of MHSA licensed providers (i.e., psychiatrists, psychologists, and social workers, etc.) throughout the State of Maryland who are geographically accessible, and whose appointment schedules are such that they are available to see State employees and retirees within a reasonable time frame, as determined by EBD.

(2) Licensed providers who are located out-of-state.

(3) Providers who accept Medicare as payment both in and out-of-state.

(4) Provision of a network that includes both in and out-of-state hospitals and medical facilities which provide MHSA services.

B. Customer Service

Provide a customer service operation, to include:

(1) A call center staffed from at least 8:00 a.m. to 5:00 p.m., Monday through Friday, local time, except on State-observed holidays.

(2) Toll-free, 24-hour, 7 days a week telephone number exclusive to the State that is available to facilitate State participants' access to services.

(3) A designated staff, trained in crisis intervention, available 24 hours per day, 7 days per week, to respond immediately to emergency or crisis telephone calls from participants and their covered dependents.

(4) An Account Service Manager who will serve as a liaison between the contractor and

the State. This individual will work full-time on-site at the State's 301 W. Preston Street building from October 1, 2000 through March 31, 2001. After March 31, 2001, the on-site representative must be available to work on-site at that location on a schedule to be mutually agreed with the State, with at least one day on-site per week.

The Account Service Manager must demonstrate previous experience in assisting with problems, issues or concerns experienced by enrollees when attempting to access MHSA and EAP benefits.

The State will provide on-site office space, including basic office furniture, and local telephone service connection, for the Account Service Manager's use when working on-site in accordance with the agreed schedule.

(5) Prepare and distribute a provider directory at least annually to each participating member, to include information about providers' office locations, office telephone numbers, providers' professional licensure and any professional information.

(6) Maintain an eligibility file that identifies eligible members to network providers. See Attachment N for minimum specific eligibility data elements to be maintained.

(7) Provide Explanations of Benefits (EOBs) to eligible members detailing payments to facilities and providers for services rendered and the amounts applicable to each service.

(8) Provide claim forms (if used) within two working days from the date of request.

(9) Provide qualified staff available to answer questions on plan eligibility, plan guidelines, benefit levels and claim procedures. Disabled individuals must be provided with adequate access to the customer service options.

C. Enrollment Services

(1) Accept the State's format of eligibility information using the State's File Transfer Protocol (FTP). All eligibility must be posted within two working days.

(2) Develop descriptive plan information for the Open Enrollment booklet.

(3) Attend Open Enrollment Health Benefit Fairs each year of the contract, including options years, to answer questions and provide plan overview information.

(4) Provide Summary of Plan Description and annual Summary of Material Modifications as required by law.

(5) Develop and provide paper claim reimbursement forms for plan members.

D. EAP Services

The contractor shall administer an EAP program that includes treatment for problems that may adversely affect the member's job performance, such as: marital, work related or physical problems; trauma or crisis intervention; addictions and other situations. In administering the EAP program, the contractor shall:

(1) accept only EAP referrals made by the State EAP Coordinator;

(2) coordinate with the EAP provider(s) to ensure that an effective and appropriate treatment plan is developed that meets the certification standards of the Alcohol and Drug Abuse Administration of the State Department of Health and Mental Hygiene;

(3) ensure the appropriate exchange of information between the EAP provider and the State EAP unit (i.e., summary reports, etc.);

(4) ensure that the provider delivers no more than three hours of EAP counseling (i.e., one three-hour session, or three one-hour sessions or any combination that does not exceed the allowable three hours);

(5) ensure that the specified EAP counseling is administered and completed within sixty (60) days of the member's initial visit, or other time frame with prior notification to and approval by the State EAP Coordinator;

(6) ensure that providers are reimbursed at the contractor's established reimbursement rates, and ensure that the provider does not assess any additional cost to the referred member;

(7) ensure that no EAP provider referrals are made to deliver EAP services to State employees without the permission of the referred employee; and

(8) integrate the established EAP components into the MHSA benefit plan.

E. Management Reports

The contractor must provide routine management reports to enable the State to effectively manage the MHSA and EAP programs and to monitor and project expenditures. A specific list of management reports to be provided appears as Attachment H.

F. Data Reporting

The contractor shall report utilization management data to the State's utilization management database system contractor on a calendar quarter basis (quarters ending March 31, June 30, September 30 and December 31). The contractor's quarterly reports shall include the data elements listed and be provided in the format specified in Attachment G. All data must be reported in an "unscrambled" format, with actual Social Security numbers attached to each record. Data must be submitted no later than the 10th business day of the month following

the end of the calendar quarter.

G. Enrollee Satisfaction Survey

The contractor shall perform an annual member satisfaction survey specific to the State's MHSA and EAP program. The design, scope and timing of each annual survey must be approved by the State. The survey must include questions designed to ensure that the performance standards applicable to this contract are being met. The contractor shall be responsible for carrying out all work involved with the survey.

H. Performance Standards

The contractor must meet established performance standards as described in Attachment F, or otherwise agreed to by the contractor and the State.

I. Claims Processing

The contractor must provide timely, accurate and prompt tracking and processing of claims either by a paper process or an electronic process.

Upon completion of the contract, the contractor must transfer claim information and other administrative records to any successor vendor without additional charge to the State.

J. Compliance with Mandates and Standards

The contractor shall comply with all standards required under state and federal laws and regulations (e.g., HIPAA, EDI and privacy standards, etc.) and shall meet any state mandated benefit provisions that may be required during the term of the contract.

K. Transition Protocols

The contractor must accommodate a transitional period for individuals that are receiving MHSA treatment on the effective date of the new contract and the transitional period following completion or termination of the contract to be awarded under this RFP.

Offerors are required to submit their transition protocols with their technical proposals. Technical proposals must cover the transition from the current vendor to the contract awardee and the transition from the contract awardee to the successor contractor.

L. Banking Arrangements

The contractor will be responsible for payment of claims to all providers through a bank account maintained by the contractor. All account reconciliations, check stock, maintenance of the account will be handled by the contractor. The State will reimburse the contractor for claims on a semi-monthly basis and will pay administrative fees on a monthly basis as follows:

Claims Reimbursement:

On a semi-monthly basis, the contractor will ensure that a proper invoice signed by authorized personnel be provided to the State. The invoice should include the following:

a) Period covered - semi-monthly claim period covered by the invoice, i.e., 01/01/2001 through 01/15/2001.
b) Invoice date - Date invoice was prepared.
c) Invoice amount - Dollar amount of claims to be reimbursed detailed as follows:

    1) Participants separated by active, retiree, satellite and direct bill - COBRA.
    2) Calendar Year covered by claims paid, ie. run-out, incurred data. Claims to be separated by year incurred.
    3) Summary report, to include totals of all categories.

On a semi-monthly basis, the contractor will provide a claim data to support the semi-monthly invoice submitted to the State. The contractor agrees to provide this data in a format to be determined by the State.

The State will provide a payment to the vendor by the 15th of the month for the claims period from the first through the 15th of the month and a payment on the last day of month for the balance of the month. The initial estimated claims reimbursement to the contractor will be based on claims for the last billing cycle covered by the current contract. This amount will be provided to the contractor by the 15th of the month (1/15/2001). The State will not provide an advance but will provide an estimated payment of claims which the contractor will have paid to providers. After the initial estimated payment, semi-monthly claims payments will be based on a reconciliation process. The second payment will be calculated on two figures:

1) a payment for 1/16/2001 through 1/31/2001 will be based on actual claims from 1/01/2001 through 01/14/2001.
2) an adjustment for the Cycle period 1 by determining the difference between the initial estimated payment for the Cycle period 1 versus the actual claims paid by the PBM for the Cycle period 1. This difference will be added or subtracted to the payment for Cycle period 2.

Example of the calculation

VENDOR #	**Mental Health PaymentCalculation**		
	CYCLE PERIOD #2001-02		**Due Date: 01/31/01**
Payment for Cycle Period 01 01/01/01-01/15/01			**Payment for Cycle Period 02 01/16/01-01/31/01 A**
	Based on claims 12/16/00-12/31/00		Based on claims 01/01/01-01/15/01
1000-ACTIVES	186,133.04		132,897.24
2000-SATELLITES	8,547.42		60,333.95
3000-COBRA	2,476.49		83,642.01
4000-RETIREES	35,277.91		2,266,573.45
Total Payment	**232,434.86**		**5,243,446.65**
Actual Claims Cycle Period 01			
1000 - ACTIVES	132,897.24		
2000 - SATELLITES	6,333.95		
3000 – COBRA	3,642.01		
4000 - RETIREES	66,573.45		
Total claims 01/01/01-01/15/01	**5,243,446.65**		
Adjustment for Cycle Period 01 01/01/01-01/15/01			
1000-ACTIVES	(123,235.80)		(123,235.80)
2000-SATELLITES	(8,213.47)		(8,213.47)
3000-COBRA	(6,834.48)		(6,834.48)
4000-RETIREES	(156,704.46)		(156,704.46)
Total Adjustment B	**(294,988.21)**		**(294,988.21)**
Payment for Cycle Period 02 01/16/01-01/31/01			
1000-ACTIVES			2,709,661.44
2000-SATELLITES			52,120.48
3000-COBRA			76,807.53
4000-RETIREES			2,109,868.99
Total Payment Cycle Period 02	**A + B**		**4,948,458.44**

Administrative Fees:

Administrative fees will be paid on a monthly basis. The State will send a payment to the TPA for administrative fees by approximately the 15th of each month. The State will calculate the payment based upon State enrollment records for plan participants of the PPO and POS plans times the administrative fees quoted in Attachment I, Financial Proposal, for the categories: actives, retirees, satellites and direct pay/COBRA. Documentation will be sent to the TPA detailing the calculation by category. The TPA will be responsible for reconciling payments to the TPA's enrollment records.

3.4 DELIVERABLES/DELIVERY SCHEDULE

The contractor must meet the following implementation schedule:

DATE	ACTIVITY
Upon contract commencement	Begin implementation meetings with the State of Maryland
Within 7 calendar days of contract commencement	Start development of information transfer and vendor activities/transition protocol with current vendor
30 calendar days after contract commencement	Complete development of information transfer and vendor activities/transition protocol
September, 2000	Attend Benefit Coordinators Training Sessions
October, 2000	Attend Open Enrollment and Benefit Fairs
January 1, 2001	Commence Benefit Coverage

3.5 QUESTIONNAIRE

The following questions are designed to solicit information critical to the State's evaluation of the offeror capabilities in terms of the evaluation criteria identified in Section 4.1 of this RFP. Although the offeror's standard material may contain the requested information, the responses in this section will be an important/critical component in the evaluation. In responding, offerors should repeat each question, followed by the answer. Answers should be concise, but complete. Offerors must respond specifically to each question, regardless of whether the information appears in or may be gleaned from other sections of the offeror's proposal. Failure to respond in this section to all questions may result in rejection of the offeror's proposal.

To assist offerors in the preparation of their responses, a disk copy of this questionnaire in Microsoft Word 97 or WordPerfect 6.1 is available. The questionnaire is also available as part of the RFP on the DBM Internet Website at www.dbm.state.md.us, select "procurement".

ORGANIZATION

Organization Name:_____

Primary Contact:_____

Title:_____

Headquarters Address:_____

_____

_____

Telephone Number:_____

Fax Number:_____

E-Mail Address:_____

1. Provide a brief summary of the history of your company and information about the growth of your organization on a national level and within the State of Maryland. Provide the following information about your company:

    a. Organization's legal name
    b. State of incorporation or headquarters
    c. Date of incorporation or founding

2. Describe any significant litigation and/or government action taken, proposed or pending against your company or any entities of your company during the most recent five (5) years.

3. Provide the addresses, including city and state, proposed to be utilized for the following activities for the State account. If more than one of any of the following will work on the State of Maryland contract, please provide the requested information for all such offices.

    a. Corporate/Firm Management Office
    b. Customer Service Office
    c. Provider Service Office
    d. Account Management/Client Services Office
    e. Technical Support Office
    f. Office responsible for general servicing of this account

4. Provide the names, location, telephone numbers and brief resumes for each of the following proposed contacts for the State of Maryland:

    a. The person representing your company during the proposal process
    b. Primary account service representative
    c. Account manager
    d. Medical director
    e. Customer service manager

f. Claims manager

5. a. Explain your organization's ownership structure, listing all separate legal entities. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.

b. Describe how long the current ownership structure has been in place.

c. Note any changes in ownership structure that have occurred within the last two years.

d. Note any changes in ownership structure anticipated to occur within the next two years.

e. List any ownership interest your company has in any business that provides a service or product related to medical care, including any contractual relationship or ownership of any facility or provider of MHSA or EAP services. Describe the relationship.

6. Provide a profile of your MHSA and/or EAP business for each of the last three calendar years (1999, 1998, and 1997 using the format of the following tables). Total dollar volume should be combined administrative and claim receipts.

Mental Health/Substance Abuse Administration	**1997**	**1998**	**1999**
Total client base			
Dollar amount of claims paid			
Administrative only dollar volume			
Number of clients			
Number of employees/retirees covered			
Public sector clients			
Dollar amount of claims paid			
Administrative only dollar volume			
Number of clients			
Number of employees/retirees covered			
Clients that terminated during the year			
Dollar amount of claims paid			
Administrative dollar volume			
Number of clients			
Number of employees/retirees covered			

Employee Assistance Program Administration	**1997**	**1998**	**1999**
Total client base			
Dollar amount of claims paid			
Administrative only dollar volume			
Number of clients			
Number of employees/retirees covered			
Public sector clients			
Dollar amount of claims paid			
Administrative only dollar volume			
Number of clients			
Number of employees/retirees covered			
Clients that terminated during the year			
Dollar amount of claims paid			
Administrative dollar volume			
Number of clients			
Number of employees/retirees covered			

7. Provide one or more copies of the most recent reports on your company's claims paying ability from the rating services of Standard & Poor, Moody's, Duff and Phelps and Best's. (If you are not rated by one or more of these organizations, please explain). Has there been any change in your ratings in the last two (2) years? If yes, explain the nature and reason(s) for the change.

8. Provide copies of your company's annual reports, audited financial statements, or if not publicly traded, the best available financial statements for your most recent three fiscal years.

9. a. Identify what general liability and errors and omissions you carry to protect your clients? Describe the type and limits of each coverage that would protect this plan. What, if any, changes do you intend to make to these coverages if you are the successful contractor?

   b. Describe your company's minimum insurance requirements.

10. List three (3) of your largest current clients in terms of membership located outside the State of Maryland. For each client provide:

Client name and address			
Name, title and telephone number of person we may contact			
Number of employees/retirees			
Total number of employees/retirees of the client			
Type of services provided (MHSA/EAP or both)			
Length of time they have been a client			

11. List three (3) of your largest current clients in terms of membership located in the State of Maryland. For each Maryland client provide:

Client name and address			
Name, title and telephone number of person we may contact			
Number of employees/retirees			
Total number of employees/retirees of the client			
Type of services provided (MHSA/EAP or both)			
Length of time they have			

Client name and address			
been a client			

12. List three (3) former clients that have terminated their contracts with your organization within the last 24 months. For each terminated client provide:

Client name and address			
Name, title and telephone number of person we may contact			
Number of employees/retirees			
Total number of employees/retirees of the client			
Type of services provided (MHSA/EAP or both)			
Length of time they were a client			
Reason for terminating contract			

Subcontractor Information - NOTE: Although the following two questions are preferred to be submitted with your proposal, the offeror is not required to identify MBE subcontractors until 10 working days after notification of the proposed contract award.

13. Do you now subcontract with any other organization(s) for professional services? If so, provide a description of your subcontracting arrangements.

14. Provide the same information requested in Questions 1 through 6, 11, and 13 through 15 for each subcontractor that you propose to have perform any of the required functions

under this contract. Clearly identify if a proposed subcontractor is a MBE certified by the State.

PROGRAM ADMINISTRATION

15. How do you propose to alert the State's key management and human resource staff regarding problem areas or trends identified from your MHSA or EAP services?

16. Provide a list of the standard coverage exclusions and limitations for your network and non-network options.

17. a. What procedures must a member follow in order to access services?
    b. Under what circumstances can someone else access MHSA services on behalf of a plan participant (i.e., spouse, parent, etc.).

18. Describe the coverage portability for members who temporarily reside, transfer, or travel to non-network service areas.

19. In the context of administering the State's MHSA benefits program for PPO and POS participants, and administering EAP services for referred employees, how will you interface with; a) the State's five (5) Health Maintenance Organization benefit plans; b) the administrators of the State's PPO and the POS medical plans; and c) the State's EAP Coordinator. Do you anticipate any difficulties with these interfaces? If so, please describe the circumstances.

20. Please complete the following table (check off those EAP treatments you offer). Are all services available <u>everywhere</u> you have offices? Please identify the specified types of counseling services that are not currently being offered at each location.

Problem	Treatment (*check if yes*)	Comments
Marital Divorce Domestic Violence Resolving Conflict		
Emotional Stress Anxiety Depression Eating Disorders Other (list)		
Addiction Chemical Dependency Other (list)		
Physical Stress Related Illness Lifestyle Complications Other (list)		
Work Related		
Family Dual Career Child/Parent Relationship Day Care Assistance Elder Care Assistance		
Trauma/Crisis Intervention		
Death/Disaster		
Financial/Legal		
Other (describe)		

21. List any behavioral health (mental or substance abuse) diagnoses which your EAP **does not** handle.

22. a. What factors determine whether your organization will proceed with EAP counseling versus referral to another provider/community agency?

b. Indicate the common types of cases which necessitate referral outside your EAP network.

c. Indicate the average percent of enrollees who need referral to a source other than your EAP counselor.

d. Indicate the specific community resources your firm prefers to use and under what circumstances. Do you sponsor or are you affiliated with any community organizations? If yes, please describe your level of involvement, and how these services are offered to members. What special arrangements do you maintain with local providers in the community, if any? Please describe the nature of such arrangements, if any, and with whom. Are there any discounted fee arrangements available to your clients for services rendered by psychiatrists, psychologists or social workers because of arrangements with these providers? Please describe. Does your organization receive any reimbursement (commissions) for referring participants to these professionals?

23. a. If a management referred employee presents for EAP counseling, at what point would you notify the employee's supervisor that the person is participating in your program?

b. Describe any issues which, when disclosed during the course of your EAP counseling, would necessitate notification to management (break in strict confidentiality)? How do you notify management in these cases?

c. Explain what your firm does when confronted with knowledge of criminal activity such as child abuse, incest, domestic violence, drug abuse, misdemeanors, felonies, etc.

d. What issues are you legally required to report and to whom?

24. Describe in detail how special non-routine enrollments, terminations and enrollment changes will be handled and verified. How soon after new members are enrolled will they be able to access services? How will you confirm that a terminated member is not able to continue to access services?

25. What safeguards are in place against an ineligible plan member attempting to or actually

using the MHSA network? Would your procedure attempt to identify the ineligible member at the point of interface with the referral counselor or would it deny benefits after the ineligible member had been serviced?

CUSTOMER SERVICE

26. a. Describe your customer service department. Include the hours of operation, staffing, experience level and training.
    b. Describe how customer services staff is notified of a client's plan provisions and changes to the plan.
    c. Is a psychiatrist available for clinically-related inquiries?

27. a. How will you ensure an incoming call to the State's exclusive customer service access line will be identified as a State member to the customer service representative?
    b. Will customer service representatives and supervisors be exclusively assigned to this account? Provide a staffing plan with the number of employees to be assigned to the State account and an organizational chart.

28. a. Are customer service representatives separate from the claims processing unit, or do claim processors have customer service responsibilities? Describe how member services and claim processing systems are integrated.
    b. Do customer service representatives have on-line access to up-to-date claim processing information?
    c. Do customer service representatives have authority to approve claims?

29. What hours will the State's toll-free telephone access be staffed in addition to the hours specified in Section 3.3? For the designated service office, how will you handle routine and emergency calls, both during regular office hours and during non-office hours?

30. Describe the education, experience and any clinical qualifications of those individuals who comprise the telephone staff responsible for receiving the initial incoming phone call from a plan member for the MHSA program.

31. Describe the process of making initial (diagnostic) assessments on the telephone. Provide a list of standard questions asked incoming callers. Describe how telephone calls will be documented.

32. How do you match the enrollee's needs with the EAP counselor's skills and expertise?

33. Identify your average actual telephone response statistics for each office that will provide services for this contract during normal business hours for the 1999 calendar year based on the following categories:

Time until initial answer	
Time until abandoned	
Time from initial answer until connected to a customer service representative	
Average talk time	
Number of calls received per day	
Number of calls abandoned per day	
Number of external calls out	

34. a. List the types of inquiries that can be handled by customer service representatives.

    b. Provide a brief description of the information available to customer service representatives.

c. Give examples of questions that will be referred to the State Employee Benefits Division.

d. Describe the grievance protocols in place for plan participants. What is your response time goal(s) for claims and other questions and complaints? Provide actual response time statistics for the most recent 12-month period measured.

35. a. What special training do telephone staff and counselors receive with regard to crisis intervention, emergency assistance?

b. In an emergency or crisis situation, what action will be taken to assist the member?

c. Are emergency calls always handled by an actual staff member? What hours of the day will members receive an answering service or system? How quickly do appropriate providers return emergency telephone calls?

d. How will you arrange for professional clinical backup for incoming calls in the event of crisis calls?

e. Describe the response when a family member calls and reports immediate threats of violence by a person who has been resistant to treatment.

f. What procedures do you have in place for monitoring a patient's status following the crisis?

g. Are you able to handle group emergency situations such as disaster recovery assistance? Please describe your policy and experience with disaster situations.

36. a. Describe the MHSA referral process including the selection of a provider.

b. Do counselors that handle the initial assessment ever provide short-term therapy or are all referrals made to other professionals?

c. Describe the quality assurance procedures, which will be used by the telephone staff for the referral operation.

d. How do you ensure that the referral process is implemented fairly, consistently and appropriately?

e. Who has overall responsibility for the referral process? What are their credentials?

37. How do you provide member support services for selecting and/or locating network providers that meet the specific needs of the patient? Do your member support services personnel have on-line access to network listings and locations to assist members with provider selection? What other member services are provided with regard to provider selection assistance? What notification and assistance do you provide plan members if a network provider terminates their contract during the plan year?

38. Is the provider directory available on the Internet? How often is the directory updated on the Internet? Please provide the web site address. Is it possible to include a link on your web site back to the State's Employee Benefits Division web site? What other services are available using the Internet?

39. Describe how the State or a plan participant can nominate providers to be considered for inclusion in the network.

40. Provide a sample of a new member communications package, including information on:

    a. How to use network services
    b. How to access member services
    c. How to file non-network claims (claim forms)
    d. Explanation of Benefit (EOB) forms

40. Provide a draft plan description to be included in the Open Enrollment booklet. The plan description must describe in detail the procedures to be used by eligible members to access MHSA and EAP services. To assist offerors in the preparation of this draft, a copy of the plan description included in the Summary of Health Benefits booklet for the plan year beginning January 1, 2000 is included as Attachment E.

CLAIM PAYING SERVICES AND ABILITY

42. Provide the following information separately for each claim office facility that would service the State.

Years in operation _____

Average Annual claim volume (dollar amount) _____

Average Number of claims per processor per day _____

Number of plans presently administering _____

Financial accuracy as a percent of

total claims dollars paid (include over/underpayments _____

Coding accuracy as a percent of total claims submitted

Staffing	**Number**	**Average Years Experience**	**Annual Turnover Rate (%)**
Processors			
Supervisors			
Managers			
Social Workers			
Psychologists			
Psychiatrists			

What are normal hours of operation, including extended or weekend shifts?

43. Will claims processors and supervisors to be assigned exclusively to the State account? Furnish a staffing plan with the number and title of employees to be assigned to the State account.

44. a. Describe your claims paying capacity and your ability to take on this account. Do you anticipate hiring additional personnel if you are awarded the contract?

b. Describe the training received by claims processors, supervisors and other management staff.

45. For the claim office proposed, what is the number of working days for a paper claim to be

processed (check issued) from the date of receipt, without coordination of benefits? On what basis do you make that representation (e.g., average turnaround time over the past 12 months)? Describe separately for network and non-network claims.

What percent of claims are processed within 14 working days from date of receipt: _____

What percent of claims are processed within 30 working days from date of receipt: _____

46. a. Describe the claim payment process from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims, discuss separately. Provide a process flow illustration.
    b. Confirm all claims will be paid in accordance with the State's benefit program.
    c. Does your system verify the appropriateness of the billed charge?
    d. Describe your ability to electronically transmit and receive claims. What is your ability for on-line interactive or batch processing?
    e. Confirm your system has the capability of providing benefits to plan members utilizing network providers without submission of a claim form (i.e. paperless claim submission).
    f. Describe your procedures for monitoring and analyzing your claim payment process.

47. a. For non-network claims, describe how claims are submitted.
    b. What is your average turnaround time for processing non-network reimbursements?
    c. What turnaround time will you guarantee for reimbursing non-network claims?
    d. Discuss the percentage capacity of non-network claims at which consistent service levels would be threatened and how you would address the problem should it arise.

48. Discuss how you will resolve questions regarding whether an admission is primarily or secondarily related to mental health or substance abuse if there are compounding related medical issues? What criteria do you use to evaluate the appropriate method to process such claims? Provide the list of evaluation criteria used.

49. If a patient is hospitalized for mental health reasons and requires medical treatment, how do you separate medical versus mental health claims? How do you integrate services with the medical plan?

50. When and under what circumstances are claims "pended"? Does a pending notice go into the system? Is there an automatic follow-up? What is the frequency of the follow-up? How many follow-ups are performed?

51. How do you avoid duplicate payments of the same claim? If duplicate payments or overpayments are made, what are your procedures for recovery of the overpayments or duplicate payments?

52. Describe how eligibility is verified.

53. How do you handle claims backlogs (e.g., overtime, switch to another office)?

54. Explain your COB procedures and the average savings that you obtain and how COB savings are calculated. Do you pursue COB prospectively or retrospectively to payments? Provide savings with and without Medicare COB? How do you know if there is other coverage? How often are records updated for new information on other coverage?

55. Explain your standard subrogation policy provisions and procedures and any options that are available, along with their advantages and disadvantages.

56. How do you determine whether services were actually provided for claims submitted?

57. Explain how unusual claims and/or charges are handled. Do you retain medical consultants for the review of any unusual claims or charges? If yes, explain the method in which such consultants are used and describe their qualifications. Also, indicate the savings in claim costs that are attributable to the use of these consultants and how that amount of savings is calculated.

Does this outside organization or person have any other business or personal relationship with your organization or any member of your organization? If so, what is the relationship?

58. Explain any other special claim administration procedures that you employ to achieve savings on claim payments, such as special investigations of claims, unbundling of claims, batch process claims for network providers, etc. Include a description of each procedure, indicating whether these procedures are optional or automatic and the savings you typically achieve by using them. Explain how savings are calculated.

59. Describe the patient appeals policy and process for claim denials.

UTILIZATION REVIEW (UR)

60. Describe the utilization review procedure for in-network and out-of-network claims. Be sure to describe any unique features of your utilization review management program. Your answer should address.
    a. Pre-authorization or Pre-certification
    b. Concurrent and Retroactive Review of ongoing treatment
    c. Ability to provide utilization statistics and savings reports
    d. UR staff credentials and qualifications
    e. UR staff training programs and monitoring
    f. Appeals process for pre-authorization or pre-certification denials
    g. Systems edits and on-line access to supporting information
    h. DRG validation

    For each component noted above be sure to provide:
    - qualifications of personnel performing the task
    - timing requirements of each task
    - how standards were developed
    - how information is captured and results are monitored

- estimated cost savings (as a percent of total behavioral health claim costs)

61. Describe your inpatient admission criteria (for inpatient acute facility or hospital program as well as for partial hospitalization or day treatment programs). Discuss primary criteria for approvals, primary criteria for denials and mitigating factors for both approval and denial.

62. Describe your arrangements for on-site evaluations of provisional admission approvals. Address the number and geographic distribution of staff available to perform on-site evaluations, the qualifications of your evaluators and the time period between provisional admission and on-site evaluation.

63 a. Explain the process for pre-certification from the time a call is initiated by the plan participant or provider to the time a telephone determination is given and written confirmation is released.

b. In what form and how quickly is notification of pre-certification provided to the attending physician, hospital, patient, claims administrator and client?

c. Describe how the process would differ in a crisis situation.

64. a. What is the process for assigning pre-certification, large case management cases, admission denials, and appeals to physicians for review?

b. What percent of cases typically require physician involvement?

c. At what point is physician involvement initiated and how quickly can the review be obtained?

65. What criteria are used to identify cases for medical management? If a list is used, please provide a copy of the list. When and how is case management initiated?

66. What utilization information do you require your network providers to report? Describe the process for providing this information.

67. Provide the ALOS and Average Visits per Case for calendar year 1999 and requested below:

Level of Care	ALOS/AVG Visits Per Case	Units/1,000 Covered Lives
Inpatient		
Residential Treatment		
Partial Hospitalization		
Intensive Outpatient		
Outpatient		
Alternative Settings		

68. Some of our agencies (i.e. University of Maryland), currently provide internal EAP services to their employees, which are in addition to services that are available through the State's EAP unit. How would you coordinate with those EAP programs to allow their participation in decisions concerning preauthorization and treatment for these clients?

69. Briefly explain any financial incentives given to providers to comply with utilization management protocols or treatment benchmarks. Include withholds, bonuses or other arrangements that are tied directly to provider utilization results and outcomes.

70. Describe the education you provide to plan members and network providers. Include sample materials and indicate frequency of educational sessions.

Information Services and Data Reporting

71. The State requires a number of regular monthly, quarterly and annual claim management reports described in Attachment H. Indicate for each report whether or not you can provide such a report, and the frequency and timing of each report. Provide an example of each type of report.

All reports must be provided for each of the four (4) Groups for the State account (Active, Satellite, Retiree, and Direct Pay), and also for all Groups Combined. Substance Abuse information should be separate from Mental Health information as described in Attachment H.

72. How will you provide the State with a report about the number of appeals filed because of denial of benefits and an explanation of how these appeals were resolved? How often will this information be provided (monthly, quarterly, annually)?

73. Describe any other claim/management reports you would be able to supply to the State at no additional charge and the frequency with which the reports could be provided.

74. a. Describe your computer system security measures.
    b. Describe the system backup and disaster recovery procedures for your medical claims and network systems.
    c. How often are the systems tested? When were the systems last tested and what were the results?
    d. Over the latest 12 months, how many times was the system down for more than one hour?

75. Provide a statement regarding your company's Y2K compliance status. Include specific descriptions of any system issues that could affect the State's benefits and payroll systems. Describe any system failures that occurred due to the year 2000 date change, including actions and time taken to correct the problems.

76. Is your network and/or mainframe processing support fully dedicated to your operations or do you share it with other organizations? If not fully dedicated, indicate the organizations that share the systems.

77. What is the current claims processing capacity of your system? Describe how claims history files are maintained. Indicate how long claims history files are maintained.

NETWORK STRUCTURE AND SERVICES

78. Describe the network structure you are offering to the State for (1) MHSA and (2) EAP. Include in your description any distinguishing features, including total number of providers in the network. Also indicate if this is an existing network or if the network is to be created for this RFP. Describe network leasing arrangements that impact any portion of the proposed network.

79. What is the relationship of EAP service providers to other MHSA service providers? Are EAP providers excluded from delivering other MHSA services under this contract? Are MHSA providers eligible and able to deliver EAP services? If not, please explain.

80. Which of the following facilities or services are included in your MHSA network:

Facility/Services	Yes or No	Comments
Inpatient psychiatric facilities		
Inpatient chemical dependency facilities		
Residential treatment centers		
Halfway houses		
Partial hospitalizations		
Outpatient services (mental health)		
Outpatient services (chemical dependency)		
Home-based services		
Other (s) (please specify)		

81. a. Describe the general credentialing process and minimum criteria for a (1) MHSA and (2) EAP provider to be selected for your network. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If process differs by type of provider, please indicate and describe separately.

b. Describe in detail any specialized training, ongoing education or qualifications you look for in providers.

c. Do you negotiate contracts with individual providers, groups of providers, or both?

d. Describe the recredentialing process, including timing and percentage of MHSA and EAP providers who are recredentialed each year.

e. Provide the number of years that a contract may be in effect.

f. Do you require that all participating providers maintain a 24-hour answering service? If so, will the answering service provide information to callers to facilitate the member accessing other service providers?

82. For your panel of network physicians complete the following table. Check off those elements that are included in the selection process and provide the percentage of network physicians that satisfy the following selection criteria elements.

Criteria	**MHSA Provider Standard Selection Criteria** ***(check if yes)***	**Percentage of MHSA Providers that Satisfy Criteria**	**EAP Provider Standard Selection Criteria** ***(check if yes)***	**Percentage of EAP Providers that Satisfy Criteria**
Require Unrestricted State Licensure				
Review Malpractice Coverage and History				
Require Full Disclosure of Current Litigation and Other disciplinary activity				
Require Signed Application/ Agreement				
Require Current DEA Registration				
Review Adherence to State and Community Practice Standards				
On-site Review of Office Location and Appearance				
Review Hours of Operation and Capacity				
Consider Hospital Admitting Privileges for MHSA providers				
Require Board Certification for MHSA providers				
Review Practice Patterns and Utilization Results				
Require Advanced Degree for EAP Providers, list				

83. List any accreditation your EAP network presently holds. Indicate whether or not your EAP program is accredited by the Employee Assistance Society of North America (EASNA) and follows the guidelines of the EASNA.

84. Are the counselors employed by the EAP or are they independent mental health care professionals that maintain their own active practices in addition to servicing the needs of EAP participants? If counselors are EAP employees, are they full-time staff? Describe in detail the nature of your organization's relationship with the EAP counseling staff.

85. For the service areas that will service the State, provide the number of MHSA providers who have been removed or voluntarily terminated the network in the past 24 months. What were the reasons for removal or voluntary terminations?

HISTORY – MHSA PROFESSIONALS

	Number of Providers	**Percent of Providers**	**Primary Causes for Terminations**
Social Workers			
Removed by organization			
Provider voluntarily left			
Psychologists			
Removed by organization			
Provider voluntarily left			
Psychiatrists			
Removed by organization			
Provider voluntarily left			

86. a. Describe your organization's objectives and efforts regarding provider relations.
    b. Is there an oversight committee that addresses provider issues?
    c. List the five most common complaints by your providers.
    d. What procedures are in place to monitor network physician grievances?
    e. Describe your standards or protocols for monitoring provider practice patterns, treatment outcomes and telephone responsiveness.

87. a. Describe the programs used to monitor and evaluate quality medical care delivered through the provider network.
    b. Is there a formal evaluation structure?
    c. Are established criteria used to guide program services?

d. Describe the means used to direct feedback to providers.

e. What arrangements exist to ensure physician input and compliance with the quality assurance review?

88. a. Will you expand your current MHSA and EAP provider networks in order to service the State of Maryland?

b. How will you increase staff to support the expanded provider network?

c. How will you recruit clinicians as requested by the State in response to employee needs?

d. If a specialist is not available in your network, how are referrals handled?

e. How is specialty care such as child psychiatry handled?

f. How are referrals made for specialty care if the provider is not in the network?

89. How will you coordinate EAP referrals to MHSA providers outside of your network (e.g., for HMO plan participants and PPO and POS plan participants using out-of-network service providers)?

90. List the number of MHSA network providers for the State's service area that are credentialed or have clinical expertise by the following type of treatment. Include the average years of experience.

Specialty	Social Workers		Psychologists		Psychiatrists	
	# of	Avg. Years Experience	# of	Avg. Years Experience	# of	Avg. Years Experience
Marital						
Emotional						
Chemical Dependency						
Work Related						
Traumatic Event						
Child/Parent						
Legal/Financial						
All Areas						

91. Please check off what forms of reimbursement you negotiate with MHSA network providers?

Provider Type	Reduced/Discounted Fee-for-Service	Per Diem	Capitated
Social Workers			
Psychiatrists			
Psychologists			
Other Professionals			

93. Hospitals in Maryland regulated by the Maryland Health Care Commission will be part of the preferred facility network. Describe the terms of your MHSA and EAP provider arrangement with each facility, including those outside Maryland. Identify any discounts for which you are eligible (i.e., SAAC or prompt pay).

94. Describe how your organization evaluates potential hospitals based on the following quality of care measures:

a. Joint Commission on Accreditation of Health Care Organizations (JCAHCO) accreditation and licensure.
b. Hospitals' credentialing requirements and sanctioning protocols for admitting providers.
c. Internal quality assurance programs, including organization of quality assurance committee and documentation of activities and results.
d. Malpractice claims and settlements.
e. History of disciplinary actions (e.g., Medicare program suspensions, loss of JCAHCO accreditation).
f. Perception of hospitals by the communities served.

95. Explain how your organization evaluates potential hospitals based on capacity and access issues, including occupancy rates, certificate of need activity, and capital improvement plans.

96. How often are network fees, capitations and out-of-network allowances updated?

97. Describe how out-of-network/non-network providers are reimbursed. How do you determine and define "reasonable and customary" charges?

98. If capitated arrangements are negotiated, please describe what services are capitated and how capitations are derived? Are supplemental capitations available?

99. Do you track and collect data on provider reimbursements by provider (MHSA and EAP)? What data is captured and tracked? Are MHSA and EAP providers terminated for improper billing practices? If not, why not? Describe billing practices that have been grounds for termination.

COVERAGE OF ELIGIBLE PARTICIPANTS

100. a. Provide the total number of MHSA providers as requested in Table 1 for the in-state network, in each county and in Baltimore City.

b. Indicate on Table 1 the providers in each county and in Baltimore City that are accepting new patients.

100. Provide the total number of MHSA providers as requested in Table 2 for out-of-state network, by state.

102. Provide the total number of inpatient and outpatient facilities as requested in Table 3 for the in-state network. Also include the name of all facilities.

103. a. Provide the total number of EAP providers as requested in Table 4 for the in-state network, in each county and in Baltimore City.

b. Indicate on Table 4 the providers in each county and in Baltimore City that are accepting new patients.

104. Provide the total number of EAP providers as requested in Table 5 for out-of-state network, by state.

TABLE 1
MHSA PROFESSIONALS IN MARYLAND

County	No. of Psychiatrists	Percent of Psychiatrists Accepting New Patients	No. of Psychologists	Percent of Psychologists Accepting New Patients	No. of Social Workers	Percent of Social Workers Accepting New Patients	No. of Other Professionals	Percent of Other Professionals Accepting New Patients
Allegany								
Anne Arundel								
Baltimore City								
Baltimore County								
Calvert								
Caroline								
Carroll								
Cecil								
Charles								
Dorchester								
Frederick								
Garrett								
Harford								
Howard								
Kent								
Montgomery								
Prince George's								
Queen Anne's								
Somerset								
St. Mary's								
Talbot								
Washington								
Wicomico								
Worcester								
Total								

TABLE 2
MHSA PROFESSIONALS IN OTHER STATES

State	Psychiatrists	Psychologists	Social Workers	Family Therapists	Other Professionals	Total
Alabama						
Alaska						
Arizona						
Arkansas						
California						
Colorado						
Connecticut						
District of Columbia						
Delaware						
Florida						
Georgia						
Hawaii						
Idaho						
Illinois						
Indiana						
Iowa						
Kansas						
Kentucky						
Louisiana						
Maine						
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri						
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey						
New Mexico						
New York						
North Carolina						
North Dakota						
Ohio						
Oklahoma						
Oregon						
Pennsylvania						
Rhode Island						
South Carolina						
South Dakota						
Tennessee						
Texas						
Utah						
Vermont						

State	Psychiatrists	Psychologists	Social Workers	Family Therapists	Other Professionals	Total
Virginia						
Washington						
West Virginia						
Wisconsin						
Wyoming						
Total						

TABLE 3
MHSA FACILITIES IN MARYLAND

State	Number of Network Inpatient Facilities	Number of Network Outpatient Facilities	Name of all Hospital and Facility Affiliations* *(staff/admitting privileges)*
Allegany			
Anne Arundel			
Baltimore City			
Baltimore County			
Calvert			
Caroline			
Carroll			
Cecil			
Charles			
Dorchester			
Frederick			
Garrett			
Harford			
Howard			
Kent			
Montgomery			
Prince George's			
Queen Anne's			
Somerset			
St. Mary's			
Talbot			
Washington			
Wicomico			
Worcester			
Total			

*Provide a separate listing for each Hospital and Facility by County and City.

TABLE 4
EAP PROFESSIONALS IN MARYLAND

County	No. of Psychiatrists	Percent of Psychiatrists Accepting New Patients	No. of Psychologists	Percent of Psychologists Accepting New Patients	No. of Social Workers	Percent of Social Workers Accepting New Patients	No. of Other Professionals	Percent of Other Professionals Accepting New Patients
Allegany								
Anne Arundel								
Baltimore City								
Baltimore County								
Calvert								
Caroline								
Carroll								
Cecil								
Charles								
Dorchester								
Frederick								
Garrett								
Harford								
Howard								
Kent								
Montgomery								
Prince George's								
Queen Anne's								
Somerset								
St. Mary's								
Talbot								
Washington								
Wicomico								
Worcester								
Total								

TABLE 5
EAP PROFESSIONALS IN OTHER STATES

State	Psychiatrists	Psychologists	Social Workers	Family Therapists	Other Professionals	Total
Alabama						
Alaska						
Arizona						
Arkansas						
California						
Colorado						
Connecticut						
District of Columbia						
Delaware						
Florida						
Georgia						
Hawaii						
Idaho						
Illinois						
Indiana						
Iowa						
Kansas						
Kentucky						
Louisiana						
Maine						
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri						
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey						
New Mexico						
New York						
North Carolina						
North Dakota						
Ohio						
Oklahoma						
Oregon						
Pennsylvania						
Rhode Island						
South Carolina						
South Dakota						
Tennessee						
Texas						
Utah						

State	Psychiatrists	Psychologists	Social Workers	Family Therapists	Other Professionals	Total
Vermont						
Virginia						
Washington						
West Virginia						
Wisconsin						
Wyoming						
Total						

105. Provide the following provider data sufficient for a GeoAccess study. Data should be provided in ASCII format on a 3.5" diskette. Include a data layout description. For each provider the following items are requested:

TIN

ZIPCode (5-digit)

Type of provider code (1 = Social Worker, 2 = Psychiatrist, 3 = Psychologist)

Only providers with open practices should be included. Also, providers with more than one office should only be included once based on their primary office location.

QUALITY

DISEASE MANAGEMENT

106. a. Define any disease management programs included in your proposal.

b. How does your disease management program differ from your utilization review?

c. Provide specific examples and specific illnesses/conditions that are managed.

d. Describe your levels of expertise and resources dedicated to disease management outcomes.

e. Describe how disease management outcomes are measured and how results are used.

f. How will these programs impact the quality and cost of the State's Plan?

AUDITING

107. a. Describe in detail the claims auditing procedures established by your company (frequency, extent, etc.).

b. Will you supply a copy of all such reports to the State?

c. Describe how you ensure that the proper amount is reimbursed to the providers.

d. What safeguards exist to prevent non-state claims from being charged to the State?

e. What safeguards exist for preventing breaches in patient confidentiality with regard to medical claims information?

108. Provider Audits - Describe the procedures in place to audit the quality of service being rendered by network providers. Include the following information:

On-Site

a. Percent of providers audited annually

b. Percent of random audits performed

c. Percent of audits performed/reviewed by independent agents. (Provide name, credentials and role of independent auditors.)

d. Percent of contracts terminated due to result of audit

e. Most common reason for termination

f. Is the right to audit included in your standard provider contracts? (Yes/No)

g. How will the State receive a copy of the audits?

h. How are recoveries credited to the State?

QUALITY MANAGEMENT

109. a. List the key personnel or committee members who are responsible for setting clinical quality standards, and overseeing any outcomes research or clinical studies. Include a brief summary of their credentials and past experience.

b. Summarize the quality assurance programs your company has in place to ensure that proper administration and dispensing are being provided.

SATISFACTION SURVEY

110. a. Describe your proposed process for conducting the annual State member satisfaction survey. Describe your sample selection methodology so the State can be assured of a statistically valid result.

b. Does an outside organization perform the survey?

c. Provide a copy of the results of your most recent survey.

IMPLEMENTATION AND ACCOUNT MANAGEMENT

111. Provide a detailed implementation plan that clearly demonstrates the offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on January 1, 2001. This implementation plan should include a list of specific implementation tasks/transition protocols and a timetable for initiation and completion of such tasks, beginning with the contract commencement and continuing through the effective date of operation (January 1, 2001). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. A detailed organizational chart as well as resumes should be included.

112. Provide a detailed management plan that clearly demonstrates the offeror's ability to manage this program on an ongoing basis.

a. The management plan should include the name, title and resume of the person with overall responsibility for planning, supervising, and performing account support services for the State. The management plan should also note what other duties, if any, this person has and the percentage of this person's time that will be devoted to the State.

b. The management plan should also include an organizational chart identifying the names, functions, and reporting relationships of key people directly responsible for account

support services to the State. It should also document how many account executives and group services representatives will work full-time on the State's account, and how many will work part-time on the State's account.

c. The management plan should describe account management support, including the number of meetings to be held with the State annually (not less than quarterly), information to be reviewed at each meeting, frequency of ongoing communications, and assurance of accountability for account services satisfaction. It should identify the location of all service centers that will be used to service this contract. It should also include the mechanisms and processes in place to allow Employee Benefits Division personnel to communicate with account service representatives; the hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The Employee Benefits Division requires identification of an account services manager to respond to inquiries and problems, and a description of how the offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and a description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract.

113. List any additional or optional services that you offer without additional charge that have not been requested.

114. Describe the benefits that will accrue to the Maryland economy as a direct or indirect result of your performance of this contract.

a. Indicate the amount or percentage (but not both) of contract dollars to be recycled into Maryland's economy in support of the contract through the use of Maryland subcontractors, Maryland suppliers, MBEs, and Maryland joint venture partners. Be as specific as possible. Provide a breakdown of expenditures in this category.

b. Indicate the number and type of jobs for Maryland residents resulting from this contract. Indicate job classifications, number of employees in each classification, and the

aggregate payroll to which you commit at both prime and, if applicable, subcontract levels.

c. Estimate tax revenues to be generated for Maryland and its political subdivisions as a result of this contract. Indicate tax category (sales tax, payroll tax, inventory tax, and estimated personal income tax for new employees).

d. Indicate other benefits to the Maryland economy, which you promise will result from the award of this contract. Please describe the benefit, its value to the Maryland economy, and how it will result from the contract award

SECTION 4. EVALUATION CRITERIA AND SELECTION PROCEDURE

4.1 EVALUATION CRITERIA

Evaluation of the proposals will be based on the criteria set forth below and developed from both the technical proposal and the financial proposal. In evaluating the proposals, technical merit will receive greater weight than price.

The following criteria, listed in order of descending importance, will be used to evaluate the quality, completeness and acceptability of the offerors' technical proposal.

1. Network

    a. Network Structure and Services
    b. Coverage of Eligible Participants

2. Organization

    a. Experience
    b. Past Performance on Similar Contracts
    c. History and Structure

3. Administration

   a. Program Administration
   b. Customer Services
   c. Claim Paying Services and Ability
   d. Utilization Review
   e. Information services and data reporting

4. Quality

   a. Disease Management
   b. Auditing
   c. Quality Management
   d. Enrollee Satisfaction

5. Proposed Implementation and Account Management

6. Maryland Economic Impact

4.2 SELECTION PROCEDURE

The contract will be awarded in accordance with the competitive sealed proposals process under Code of Maryland Regulations 21.05.03. The competitive sealed proposals method is based on discussions and revision of proposals during these discussions.

Accordingly, the State may hold discussions with all offerors judged reasonably susceptible of being selected for award. However, the State also reserves the right to make an award without holding discussions. In either case of holding discussions or not doing so, the State

may determine an offeror to be not responsible and/or not reasonably susceptible of being selected for award, at any time after the initial closing date for receipt of proposals. Financial proposals of qualified offerors will be opened only after all technical proposals have been evaluated.

After a review of the financial proposals of qualified offerors, the Procurement Officer may again conduct discussions with the offerors. The purpose of any such discussions will be: to assure full understanding of the State's requirements and the offeror's ability to perform; to obtain the best price for the State; and to facilitate arrival at a contract that will be most advantageous to the State.

Offerors must confirm in writing any substantive oral clarification of their proposals made in the course of discussions. When in the best interest of the State, the Procurement Officer may permit offerors who have submitted acceptable proposals to revise their initial proposals and submit in writing best and final offers.

Upon completion of all discussions and negotiations, reference checks, and site visits, if any, the Procurement Officer will recommend award of the contract to the responsible offeror whose proposal is determined to be the most advantageous to the State, considering price and the evaluation factors set forth in this RFP. In making the selection, technical merit will receive greater weight than price.

SECTION 5. PROPOSAL FORMAT

5.1 GENERAL

The proposal should address all points and questions outlined in the RFP. It should be clear and concise in response to the information and requirements described in the RFP. Do not include any promotional items or items not directly requested.

5.2 FORMAT OF THE PROPOSAL

Proposals must be submitted in two separate volumes, technical and financial. Technical volumes must be sealed separately from financial volumes but submitted simultaneously at the Issuing Office. An unbound original, so identified, and eight (8) copies of each volume are to be submitted.

Each offeror is required to submit a separate sealed package for each volume which is to be labeled “Technical Proposal” (Volume I) and “Financial Proposal” (Volume II) (respectively). Each sealed package must bear the RFP title, name and address of the offeror, the volume number (I or II), and the closing date and time for receipt of the proposal on the outside of the package. A transmittal letter and a statement acknowledging receipt of any and all addenda should accompany the technical proposal. The sole purpose of this letter is to transmit the proposal; it should be brief and signed by an individual who is authorized to commit the offeror to the services and requirements as stated in the RFP. All proposals must

be page numbered from beginning to end.

5.2.1 Volume I - Technical Proposal

The Technical Proposal shall include:

a. Executive Summary

The offeror shall condense and highlight the contents of the Technical Proposal in a separate section titled "Executive Summary." The summary shall provide a broad overview of the contents of the entire proposal and explain any deviations. Do not include any financial proposal information.

b. Offeror Qualification

Provide a detailed discussion of the Offeror's service capabilities and approaches to address the qualification outlined in Section 2 of this RFP.

c. Completed Questionnaire

Repeat each number and question as provided in Section 3.5. Provide clear and complete responses. To assist offerors in the preparation of their responses, a disk copy of this questionnaire is available as part of the RFP in WordPerfect 6.1 or Microsoft Word 97 format. It is also available through the Department's Internet Website address: www.dbm.state.md.us., select "procurement".

d. Required Submissions

Offerors must submit:

1. Completed Proposal Affidavit (Attachment B - original copy only)
2. Certified Minority Business Enterprise (MBE) Utilization and Fair Solicitation Affidavit (See Section 1.19 and Attachment D-1).
3. Financial Statements and Annual Reports (audited preferred). (See question 8).

4. Descriptive Plan Information for Open Enrollment Booklet. (See Section 3.3 Scope of Work - C. Enrollment Services)
5. Network data in ASCII format (See question 105)
6. Transition protocols (See Section 3.3)

e. Subcontractors

Offerors must identify subcontractors and the role these subcontractors will have in the performance of the contract. However, disclosure of MBE subcontractors at this point is optional.

5.2.2 Volume II - Financial Proposal

Under separate sealed cover from the Technical Proposal and clearly identified with the same information noted on the Technical Proposal, the Contractor must submit an original and eight (8) copies of the Financial Proposal. The Financial Proposal must contain all cost information in the format specified in Attachment I of this RFP.

ATTACHMENTS

In accordance with State Procurement Regulations, the Proposal Affidavit, **Attachment B**, and Certified MBE Utilization and Fair Solicitation Affidavit, **Attachment D-1**, must be completed and submitted with the Technical Proposal, and the Contract Affidavit, **Attachment C**, must be submitted at the time of notification of contract award.

ATTACHMENTS

In accordance with State Procurement Regulations, the Proposal Affidavit, **Attachment B**, and Certified MBE Utilization and Fair Solicitation Affidavit, **Attachment D-1**, must be completed and submitted with the Technical Proposal, and the Contract Affidavit, **Attachment C**, must be submitted at Contract award.